100TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 100–85
Part 2

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MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1987

MAY 21, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 1444 which on March 5, 1987, was referred jointly to the Committee on Ways and Means, and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 1444) to amend titles XI, XVIII, and XIX of the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions relating to those programs, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. INTRODUCTION

PURPOSE

The basic purpose of the Committee bill, H.R. 1444, is to improve the ability of the Secretary and the Inspector General of the Department of Health and Human Services (HHS) to protect the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Title XX Social Services Block Grant programs from fraud and abuse, and to protect the beneficiaries of those programs from incompetent practitioners and inappropriate or inadequate care.

SUMMARY

The Committee bill has four main elements, the first of which relates to exclusion of participating providers. The bill mandates the exclusion from Medicare and Medicaid of individuals convicted of program-related crimes or patient abuse or neglect. It also broad-

ens the grounds for the discretionary exclusion of health care providers from Medicare and Medicaid. In addition, the bill extends the mandatory and discretionary exclusion remedies to two other State health care programs, the Maternal and Child Health Services Block Grant, and the Title XX Social Services Block Grant. The Attorney General is authorized to deny, revoke, or suspend the controlled substances registration of any individual or entity subject to mandatory exclusion from Medicare.

Second, the Committee bill revises the current civil money penalty authorities. It clarifies the Secretary's authority to consolidate exclusion and civil money penalty determinations involving the same provider into a single administrative proceeding, and it broadens the Secretary's authority to seek injunctive relief to protect assets for the payment of civil money penalties imposed. The bill also adds, as grounds for imposing civil money penalties, the submission of claims for payment for physician services by individuals who are not licensed as physicians, who obtained their licenses through misrepresentation, or who misrepresented to the patient that they were board-certified in a medical specialty.

Third, the bill provides for criminal penalties for the submission of claims for physician services by individuals who are not licensed as physicians or who obtained their licenses through misrepresentation of cheating on a licensing exam. The bill also directs the Secretary, in consultation with the Attorney General, to clarify by regulation what payment practices are not to be treated as criminal offenses for purposes of the current law prohibitions against bribes and kickbacks.

Finally, the bill requires States, as a condition of receiving Federal Medicaid matching funds, to provide information to the Secretary regarding actions taken against health care practitioners by State licensing authorities. The bill also authorizes the Secretary to provide such information to other State licensing authorities and program agencies in order to protect the health and safety of beneficiaries and the fiscal integrity of the programs.

BACKGROUND AND NEED FOR LEGISLATION

Under current law, the Department of Health and Human Services (HHS) can exclude practitioners from participation in Medicare for a number of reasons:

Conviction of a criminal act against Medicare (Title XVIII), Medicaid (Title XIX) or Title XX of the Social Security Act;

Imposition of a civil monetary penalty for acts against Medicare or Medicaid;

Submitting false claims to Medicare;

Repeatedly providing more services than necessary to Medicare beneficiaries;

Submitting Medicare claims with charges that substantially exceed the practitioner's customary charges;

Providing services to Medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care;

Failing to keep adequate records to demonstrate the need for services rendered.

HHS has the authority to require all States to exclude practitioners from participating in Medicaid only when the practitioner is convicted of a criminal act against Medicare, Medicaid or Title XX, or where HHS has imposed a civil monetary penalty on the practitioner for acts against Medicare or Medicaid. HHS also has the authority to require all States to exclude entities that are owned or controlled by individuals convicted of such criminal acts.

If HHS excludes a practitioner for the above reasons, HHS is required to notify the State and local agencies responsible for health care licensing or certification of the suspension and to request that they invoke sanctions in accordance with applicable State law or policy.

Current law also authorizes the Secretary to impose a civil monetary penalty of up to $2,000 per item or service, plus an assessment of up to twice the amount claimed, on any person who files a claim for medical or other item or service that the person knew or had reason to know was not provided as claimed.

Finally, current law provides for criminal penalties, including fines of up to $25,000 and imprisonment for up to five years, upon conviction of certain offenses relating to kickbacks, bribes, or false claims for payment.

On May 1, 1984, the U.S. General Accounting Office (GAO) issued a report to the Secretary of HHS which concluded that there was a need to expand Federal authority to protect Medicare and Medicaid patients from health practitioners who lose their licenses. The GAO report found that Medicare and Medicaid patients are being treated in some States by health care practitioners whose licenses were revoked or suspended by another State's licensing board because they did not meet minimum professional standards. This occurred because these practitioners move to another State where they have a license and continue to practice. Such practitioners are able to treat Medicare and Medicaid patients because HHS does not have the authority to exclude them from these programs in all States based on licensing board findings and sanctions in one State. Currently, HHS is only empowered to deny payment for services furnished by a practitioner in the State in which he or she has lost a license.

A primary reason sanctioned practitioners were able to move to other States and continue practice was that other States did not learn of the practitioner's previous offenses, or when they did, many months or years had passed. When States are informed, it may take up to three years to sanction practitioners because procedures are lengthy and there is a shortage of personnel. Sanctions imposed by one State do not automatically result in sanctions being imposed by other States. State licensing laws do not always permit a State to take action based solely on another State's sanction. Further, physicians whose licenses have been revoked can enter the military and practice without a license from the State in which they are located.

Under current law, HHS can exclude practitioners only for acts committed against Medicare, Medicaid and their beneficiaries. As a result, HHS excludes relatively few of those sanctioned by State boards. For example, while State licensing boards in Michigan, Ohio and Pennsylvania sanctioned 328 practitioners between 1977

and 1982, HHS nationwide excluded only 335 practitioners from 1975 to 1982. Also, only 15 of the 328 practitioners sanctioned by the three States mentioned above were also excluded by HHS. Further, over seventy percent of HHS exclusion actions were for criminal violations against the programs. However, fifty-eight percent of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care.

In addition, HHS is unable under current law to bar from participation individuals or entities that have been convicted of defrauding patients or private health insurers or of defrauding other Federal, State or local government programs.

In summary, HHS currently does not have the authority to exclude individuals or entities from Medicare, Medicaid, the Maternal and Child Health Program and Title XX Social Services Program who have been convicted of non-program related crimes such as fraud, financial abuse, neglect of patients or unlawful distribution of a controlled substance. It does not have the authority in all cases to exclude those who have been sanctioned for defrauding or abusing the Medicaid program from participation in Medicare or vice versa. Further, HHS does not have the authority to exclude nationwide those individuals or entities that have lost their licenses to provide health care or have otherwise been sanctioned by a State licensing authority.

II. Explanation of Legislation

Exclusion from Medicare and State Health Care Programs (Section 2)

Mandatory Exclusion

The bill identifies a number of acts for which exclusion from Medicare and State health care programs is appropriate. (The bill defines State health care programs as Medicaid, the Maternal and Child Health Services under Title V of the Social Security Act, and the Social Services Block Grant under Title XX of the Social Security Act). The bill divides these actions into two broad categories: those for which exclusion is mandatory, and those for which it is discretionary with the Secretary. In those cases where individuals or entities have been convicted of certain crimes and exclusion is mandatory, the bill prescribes a minimum period of exclusion of 5 years, with certain limited exceptions.

Mandatory exclusion for program-related crimes (section 1128(a)(1) of the Social Securtity Act)

The Secretary would be required to exclude from participation in Medicare any individual or entity convicted, in Federal or State court, of a criminal offense related to the delivery of services under Medicare or Medicaid or any other State health care program. The exclusion would be for a period of not less than five years, unless the Secretary waives the exclusion upon a request from the State on the grounds that the individual or entity is the sole community physician or the sole source of essential specialized services in the community. If the Secretary excludes an individual or entity from

Medicare under this provision, the State would be required to exclude the individual or entity from participation in Medicaid and the other State health care programs for the same period as the individual is excluded from Medicare.

If an individual or entity convicted of a program-related offense involving a State health care program has not been furnishing services to Medicare beneficiaries but would be eligible to do so, it is the Committee's expectation that the Secretary would proceed to exclude the individual or entity from Medicare and then direct the States to exclude the party from the State health care programs. If the individual or entity was a type of provider that would not otherwise be eligible for Medicare payments, the Secretary could call the matter to the attention of the States and urge that they institute exclusion proceedings. In the alternative, the Secretary could follow the exclusion procedure for Medicare and direct the States to exclude the provider from the State health care programs.

While there is currently a mandatory exclusion from Medicare and Medicaid for crimes related to the delivery of health care under Medicare, Medicaid or Title XX, no minimum period of exclusion is specified, and participation in the Title V MCH Block Grant is unaffected. This provision would amend current law to require exclusion for a minimum of five years for conviction of such crimes, and to apply the exclusion to Title V as well. The Committee believes that a minimum five-year exclusion is appropriate, given the seriousness of the offenses at issue. The minimum exclusion provides the Secretary with adequate opportunity to determine whether there is a reasonable assurance that the types of offenses for which the individual or entity excluded have not recurred and are not likely to do so. Moreover, a mandatory five-year exclusion should provide a clear and strong deterrent against the commission of criminal acts.

Mandatory exclusion for crimes related to patient neglect or abuse (section 1128(a)(2)

The Secretary would be required to exclude from participation in Medicare any individual or entity convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service. The bill would establish a minimum exclusion period of five years, unless the Secretary waives the exclusion upon a request from the State on the grounds that the individual or entity is the sole community physician or the sole source of essential specialized services in the community.

If the Secretary excludes any individual or entity under this provision, the States would be required to exclude such individual or entity from participation in Medicaid or any other State health care programs for the same period of time. As in the case of providers who are convicted of program-related crimes, the Secretary could exclude from Medicare individuals and entities who are eligible to participate but are not doing so, and could follow the Medicare exclusion process to direct States to exclude providers who are not eligible to participate in Medicare.

Under current, law, the Secretary does not have the authority to exclude persons who have been convicted of criminal offenses which are not related to Medicare or other State health care pro-

grams. This provision would give the Secretary the authority to protect Medicare and the State health care program beneficiaries from individuals or entities that have already been tried and convicted of offenses which the Secretary concludes entailed or resulted in neglect or abuse of other patients and whose continued participation in Medicare and the State health programs would therefore constitute a risk to the health and safety of patients in those programs.

Permissive Exclusions

Subsections 1128(b)(1) through (b)(14) would establish discretionary authority for the Secretary to exclude individuals and entities from Medicare for specified reasons. Although the Secretary would have discretion whether to initiate an exclusion proceeding in any particular case, the bill makes it clear that, if the Secretary found that an exclusion was warranted, these authorities would have to be exercised in a manner that resulted in the exclusion of the individual or entity from all of the Medicare and State health programs for which the individual or entity was otherwise eligible to participate. Thus, if the provider were eligible to participate in Medicare, the Secretary would exclude the provider from Medicare, even if the provider had not been participating in Medicare, and would simultaneously direct the States to exclude the provider from the State health programs for the same period of time. If the individual or entity were not eligible to participate in Medicare because he or it was a type of provider that is not reimbursed under that program, the Secretary could use the Medicare exclusion procedures to direct the States to exclude the individual or entity from the State health programs for the period of time for which he or it would have been excluded from Medicare.

The bill includes among the grounds for permissive exclusion convictions relating to fraud (1128(b)(1)) and convictions relating to controlled substances (1128(b)(3)). While the Committee expects that most of these cases will result in exclusion, it wishes to give the Secretary the option to avoid exclusion if, in his judgment, exclusion would jeopardize another investigation.

The Committee recognizes that among the categories of behavior which may result in exclusion of a provider or practitioner under this bill, there is a great disparity in the seriousness of the offense and the potential harm to the Medicare program. For those categories which concern the simple failure to supply required information (section 1128(b) (9), (10) and (11)) and that concerning the submission of excessive bills (section 1128(b)(6)(A)), the Committee believes that it is inappropriate to exclude a provider or practitioner whose failure to comply is an isolated or unintentional occurrence.

Authority to exclude for conviction relating to fraud (section 1128(b)(1))

The Secretary would be authorized to exclude any individual or entity convicted under Federal or State law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or financial abuse if such offense was committed either in connection with the delivery of health care or with respect to a

program that is financed, at least partially, by Federal, State or local government.

Under current law, the Secretary does not have the authority to exclude individuals or entities convicted of criminal offenses which are not related to Medicare or Medicaid or the other State health care programs. This provision would permit the Secretary to exclude persons and entities who have already been convicted of offenses relating to their financial integrity, if the offenses occurred in delivering health care to patients not covered by public programs or if they occurred during participating in any other governmental program.

Authority to exclude for conviction relating to obstruction of an investigation (section 1128(b)(2))

The Secretary would be authorized to exclude any individual or entity convicted of interference with, or obstruction of, any investigation into any criminal offense for crimes that would require mandatory exclusion under section 1128(a) or permit exclusion under section 1128(b)(1).

Authority to exclude for conviction relating to controlled substance (section 1128(b)(3))

The Secretary would be authorized to exclude any individual or entity convicted under Federal or State law of unlawful manufacture, distribution, prescription or dispensing of a controlled substance or any other criminal offense relating to a controlled substance.

Authority to exclude for license revocation or suspension (section 1128(b)(4))

The Secretary would be authorized to exclude any individual or entity whose license to provide health care has been suspended or revoked by a State licensing authority or whose license has been otherwise lost for reasons bearing on the individual's professional competence, professional conduct or financial integrity.

The Committee heard substantial testimony from the General Accounting Office, based on its investigation of three States, and from the Inspector General of HHS, about the need to protect Medicare and Medicaid patients from practitioners who lose their licenses in one State, move to another State, and continue to treat program beneficiaries. The provisions of this bill would permit the Secretary to exclude such persons from Medicare in all States and to require the State to exclude them from participation in any State health care program.

This provision would also permit the exclusion of individuals or entities who surrender their licenses while disciplinary proceedings involving professional competence, professional conduct or financial integrity are pending. This provision will prevent unfit practitioners from avoiding exclusion through the expedient of surrendering their license before the State can conclude proceedings against them.

The Committee expects that the Secretary will not use his disrection under this authority to exclude individuals whose licenses have been suspended in the State in which they are practicing for

minor infractions not relating to quality of care, such as failure to pay licensing fees or violation of strict advertising requirements. In these limited circumstances, the exclusion penalty would, in the Committee's view, be too harsh. However, the Committee expects that the Secretary in these instances will carefully review the circumstances of the license suspension to assure himself that the minor infraction was the sole reason for the loss of license.

Authority to exclude for prior suspension or exclusion from Federal health care programs (section 1128(b)(5))

The Secretary would be authorized to exclude any individual or entity suspended or excluded from any Federal program involving the provision of health care, or from any State health care program, for reasons bearing on professional competence, professional performance, or financial integrity. Federal programs covered by this provision would include those administered by the Department of Defense or the Veterans' Administration. The purpose of the provision is to correct the anomaly in current law whereby individuals or entities found unfit to participate in one Federal health program, or in one Federally-funded State health care program, may continue to participate in Medicare or Medicaid or the other State programs.

Authority to exclude for excessive charges, unnecessary services, or failure of certain organizations to furnish medically necessary services (section 1128(b)(6))

The Secretary would be authorized to exclude any individual or entity the Secretary determines submitted requests for payment which contain charges (or costs) substantially in excess of usual charges (or costs). The Committee intends that the standard to be used in determining whether exessive charges have been submitted is the person's or entity's usual or normal charge, which may be higher than the Medicare-recognized "customary charge." This provision does not in any way alter the amount of the charge which will be recognized as "reasonable" under Title XVIII. The provision does not apply where payment is not made on either a cost or charge basis, such as under prospective payment.

The Secretary would be authorized to exclude any individual or entity that the Secretary determines has furnished, or caused to be furnished, items or services substantially in excess of the patient's needs or of a quality which fails to meet professionally recognized standards of health care. The Committee is aware that currently PROs are responsible under their contracts only for review of Medicare inpatient hospital services. Even for those Medicare inpatient services, however, there may be situations when the PRO does not make the final quality decision, such as in cases where a PRO contract is not in effect. The Committee expects that, in determining whether professionally recognized standards of health care are met, the Secretary may rely on information supplied by the Peer Review Organization (PROs), the Medicare Part B carriers, or any other reliable source.

The Secretary would be authorized to exclude a risk-sharing health maintenance organization (HMO) or competitive medical plan (CMP) or a primary care case management plan, approved

under Medicare or Medicaid, which has failed substantially to provide medically necessary items or services as required by law or contract, if the failure has adversely affected, or has the likelihood of adversely affecting, Medicare or Medicaid beneficiaries.

The first two elements of this provision would essentially recodify current law under Section 1862(d)(1), regarding conditions under which Medicare payments may be denied. The provision would also expand current law to include State health care programs. The Committee understands that, under current law, when exclusion is considered in the case of a hospital that has submitted claims in excess of usual charges, or in the case of a physician who provides services substantially in excess of the needs of patients, the hospital or physician is given a notice of the proposed sanction, an opportunity to submit an explanation in writing, and a face-to-face meeting with a representative of the Secretary prior to a decision as to whether to exclude. The Committee expects the Secretary to follow these procedures with respect to potential exclusions in such cases under the Committee bill. Where it appears that the underlying violation by the hospital or physician in such a case is an isolated or inadvertent instance, the Committee would expect the Secretary not to exclude, but rather to insist on prompt corrective action.

The new provisions affecting HMOs, CMPs, and Medicaid case management plans are intended to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions. The Committee intends for the Secretary to examine whether there was a deliberate omission or a pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons of circumstances involved. It is also expected that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards. The Committee expects that these standards could be developed by physicians involved with prepaid group practice, by other HMOs or CMPs, or by State agencies that have contracted with HMOs, with PROs, or with other organizations to conduct quality assessment in prepayment settings.

Authority to exclude for fraud, kickbacks, and other prohibited activities (section 1128(b)(7))

The Secretary would be authorized to exclude any individual or entity that has committed an act described in 1128A (relating to civil money penalties for false or fraudulent claims) or in the new section 1128B (relating to criminal penalties for kickbacks and bribes). (See discussion below regarding the new section 1128B.) The Secretary could exercise this authority to exclude an individual or entity without the necessity of imposing a civil money penalty or obtaining a criminal penalty or obtaining a criminal conviction. It is the Committee's intent that the burden of proof requirements under this authority would be those customarily applicable to administrative proceedings.

Authority to exclude entities controlled by a sanctioned individual (section 1128(b)(8))

The Secretary would be authorized to exclude any entity that has a person with an ownership or controlling interest, or that has an officer, director, agent or managing employee, who has been convicted of certain program-related offenses (described in section 1128(a) or section 1128(b) (1), (2), or (3)), or against whom a civil monetary penalty has been assessed, or who has been excluded from participation in Medicare or a State health care program.

The section would recodify section 1128(b) of current law with respect to excluding entities that have an ownership, managerial, or other substantial relationship with an individual who has been excluded or sanctioned by the program on the basis of a program-related conviction. The provision would expand the current exclusion authority to include entities that have a substantial relationship with an individual who has been excluded from Medicare or Medicaid or the other State health care programs or who has had a civil monetary penalty imposed against him.

Authority to exclude for failure to make certain disclosures (section 1128(b) (9), (10) and (11))

The Secretary would be authorized to exclude any individual or entity which fails fully and accurately to make any required disclosure regarding persons with ownership or control, or persons convicted of program-related crimes, or which fails to suply to the Secretary as requested information pertaining to the ownership of a subcontractor or to significant business transactions. In addition, the Secretary would be permitted to exclude any individual or entity that fails to provide information that the Secretary or the State Medicaid agency finds necessary to determine amounts payable, or that refuses to permit examination of its fiscal or other records as may be necessary to verify such information.

These provisions are essentially a recodification of current law under section 1866(b)(2)(C) and (G), with an expansion in the entities covered and an extension to include exclusions from the State health care programs.

Authority to exclude for failure to grant immediate access (section 1128(b)(12))

The Secretary would be authorized to exclude an individual or entity that fails to grant, upon reasonable request, immediate access to the Secretary, State agency, Inspector General, or State Medicaid fraud control unit for the purpose of performing their specified statutory functions. The Secretary would be required to define by regulation what constitutes "immediate access" and "reasonable request." The Committee intends that the regulations on "reasonable request" with respect to the review of records or documents by the Inspector General or State Medicaid Fraud Control Units will specify that this provision only apply to situations where there is information to suggest that the individual or entity has violated statutory or regulatory requirements under Titles V, XI, XVIII, XIX, or XX. With respect to determinations of compliance with Medicare or Medicaid conditions of participation or payment,

or with respect to Medicaid review and inspection requirements, the Committee recognizes that information regarding compliance will not necessarily be available prior to access to a facility or other entity; indeed, the purpose of immediate access in this circumstance is to facilitate a determination of the extent of compliance. The Committee further intends that the regulations make allowances for failure to provide immediate access if there are circumstances beyond the control of the individual or entity under review, such as in cases where the hospital record is physically in the possession of the a PRO conducting a review. The period of exclusion for individuals (but not entities) would be equal to the period during which access was denied and an additional period not to exceed 90 days as set by the Secretary.

The Committee recognizes that the Secretary's regulations implementing section 1128(b)(12) must carefully balance the interests of federal and state programs in obtaining necessary information and the interests of providers and practitioners in protecting sensitive patient care information from unauthorized or improper disclosure. Individuals and entities should have reasonable opportunity to determine that any request for information comes from a source of proper authority and to seek clarification of that authority without fear that sanction proceedings will be commenced prematurely.

Authority to exclude for failure to take certain corrective actions (section 1128(b)(13))

The Secretary would be authorized to exclude any hospital which fails to comply substantially with a corrective action necessary to prevent or correct inappropriate admissions or practice patterns under the prospective payment system, if required to do so under the provisions of section 1886(f)(2) pertaining to the review and recommendations of a PRO. This provision clarifies the sanctions available under current law and extends them to include exclusion from the State health care programs.

The Committee intends that, in making a determination to exclude an individual or entity pursuant to paragraph (6)(B) of section 1128(b), the Secretary shall make such determination in accordance with the procedures of section 1156 if the Secretary determines that Peer Review Organizations have primary responsibility for review of the items or services at issue. The Committee believes that, where applicable, PRO review is the appropriate means to determine whether the furnishing of items of services has failed to meet professionally recognized standards and believes that it would be not be appropriate for the Secretary to make such a determination independently of the primary mechanism created by Congress for that purpose.

Authority to Exclude for Default on Health Education Loan or Scholarship Obligations (section 1128(b)(14))

The Secretary would be authorized to exclude any individual who is in default on repayment of scholarship obligations or loans for health education that have been made or secured in whole or in part by the Secretary. The Secretary may not exclude an individual for default unless the Department has echausted all reasonable alternatives available to it to secure repayment. In addition, the

Secretary may not exclude any physician for default if the State requests that the physician not be excluded on the grounds that he or she is the sole community physician or the sole source of essential specialized services in a community. In determining whether to exclude a physician for default, the Secretary is required to take into account the effect of exclusion on access by Medicare and Medicaid beneficiaries to covered physician services.

The Committee emphasizes that exclusion is a remedy of last resort for collecting outstanding loan obligations. The Secretary is expected to use alternative administrative tools whenever feasible. For example, the Secretary should explore the feasibility of deducting overdue loan obligations from amounts that Medicare or Medicaid would otherwise pay for services rendered by the defaulting practitioner. Similarly, civil authority in the tax code, administered by the Attorney General, could be used to deduct loan obligations from tax refunds to individuals in default.

Due process (sections 1128 (c), (d), (e), (f) and (g))

All mandatory and permissive exclusions under sections 1128 and 1128A would be effective at such time, and upon such reasonable notice to the public and to the individual or entity to be excluded, as may be specified in regulation. An exclusion would be effective on or after the effective date specified by the notice of the exclusion.

In order to avoid disruptions in care that would be harmful to patients, and to permit an orderly transfer to another provider, payment to an excluded provider would normally be permitted under Medicare, Medicaid, and the other State health care programs, for up to 30 days for inpatient institutional services furnished to an individual admitted prior to the exclusion, and for home health services or hospice care furnished pursuant to a plan of care established before the date of the exclusion. However, the Secretary could stop payments for such patients sooner than thirty days after exclusion if the Secretary concluded that the risk to the health or safety of the patients was sufficiently serious to warrant a more immediate transfer to a different provider.

Under the bill, the notice of the exclusion under sections 1128 or 1128A would be required to state the earliest date on which the individual or entity could apply for reinstatement in Medicare, Medicaid, and the other State health care programs. The period could not be less that five years in the case of a mandatory exclusion under section 1128(a), unless the Secretary has exercised his authority to waive exclusion in the case of a sole community physician or a practitioner or entity that is the sole source of essential specialized services in a community. For individuals excluded under section 1128(b)(12), the period of exclusion is the period during which the Secretary was denied immediate access plus an additional period, not to exceed 90 days, as determined by the Secretary. In the case of all exclusions other than those under 1128(a) and 1128(b)(12), the Committee intends that, in setting the period of exclusion, the Secretary will take into consideration such factors as the seriousness of the offense, the impact of both the offense and the exclusion on beneficiaries, and any mitigating circumstances,

such as the availability of alternate providers of needed health care services.

The individual or entity excluded under Section 1128 would be entitled to resonable notice and opportunity for a hearing by the Secretary after the notice of exclusion, and to judicial review of the Secretary's final decision. These are the same notice and post-termination hearing requirements provided under current law in sections 1862(d), 1128 and 1156 of the Social Security Act.

There are currently several different procedural regulations governing the various provisions available to the Secretary to sanction individuals and entities. Although similar in many respects, the regulations also vary sufficiently that there exists a possibility of confusion on the part of affected parties. Since the Committee bill consolidates these authorities, and the Committee understands their administration will be consolidated under the responsibility of the Inspector General, the Committee intends that the Secretary promulgate, to the extent possible, a uniform set of procedural regulations.

The provisions of section 205(h) of the Social Security Act have been expressly incorporated in the bill to make clear that the review process provided for in the bill shall be the exclusive means of review for questions arising under this section (and under sections 1128A and 1156).

The Secretary would be required to notify promptly the appropriate State agencies of an exclusion from Medicare under sections 1128 or 1128A. Each State would be required to exclude or otherwise bar an excluded individual or entity from its State health care programs for the same period as the Medicare exclusion, unless the State requested and received a waiver from the Secretary, based on a judgment that the exclusion will result in program beneficiaries' not having adequate access to appropriate services.

An individual or entity excluded from participation under section 1128 or section 1128A would be permitted to apply to the Secretary for reinstatement under Medicare and the State health care program after the period of exclusion specified in the notice and at such other times as the Secretary may provide in regulation. The Secretary could reinstate such individual or entity if the Secretary determined that there was no basis for a continuation of the exclusion and there were reasonable assurances that the types of actions which were the basis for the original exclusion had not recurred and would not recur. In making this determination, the Secretary would consider the conduct of the applicant which occurred after the date of the notice of exclusion or conduct which was unknown to the Secretary at the time of the exclusion. The Committee intends that the Secretary set forth in regulation the frequency with which applications for reinstatement can be made in order to preclude unduly repetitious submissions.

The Committee bill maintains current law by providing that the decision of whether or not to grant an applicant's request for reinstatement is vested by law in the Secretary's discretion and thus is not subject to judicial review.

The Committee bill broadly defines the term "conviction" for the purposes of both the mandatory and permissive exclusions under section 1228. This definition reflects current law with respect to ex-

isting section 1228(a) and encompasses all dispositions of criminal matters in which (1) a judgment of conviction has been entered in a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of or other record of conviction has been expunged; (2) there has been a finding of guilt by a Federal, State, or local court; (3) a plea of guilty or nolo contendere has been accepted by a Federal, State or local court; or (4) the individual has entered into participation in a first offender, deferred adjudication, or other problems where judgment of conviction has been withheld, regardless of whether that individual entered a formal plea of guilty or nolo contendere.

Under current practice, the Secretary has delegated all existing suspension, exclusion, and civil monetary penalty authorities to the Department's Inspector General. The Committee believes that this delegation of authority by the Secretary is entirely consistent with the statutory mandate of the HHS Inspector General (42 U.S.C. section 3521, *et seq.*) and has resulted in the efficient administration of these authorities. The Committee expects the Secretary both to continue this existing practice and to delegate all new statutory exclusion authorities created by this bill to the Department's Inspector General.

Civil Monetary Penalties (section 3)

Under current law, the Secretary is authorized to impose a civil monetary penalty (of up to $2,000 per item or service), plus an assessment of twice the amount claimed, or any person who files a claim for a medical or other item or service that the person knew or had reason to know was not provided as claimed. Current law, in section 1128(c), also authorizes the Secretary to exclude a person, against whom a civil money penalty or assessment has been imposed, from Medicare and to direct his exclusion from Medicaid. The Committee bill consolidates and clarifies these authorities, and expands the grounds for penalties and exclusion.

The bill makes several clarifying amendments to the civil monetary penalty statute. First, the bill amends the statute to make actionable those claims a person knew or had reason to know were "false and fraudulent". This amendment is intended to clarify that the scope of the statute includes such conduct as double billing, but is not intended to change the current standard of proof regarding the requirement that a person knew or had reason to know the claim was wrongful.

The bill further clarifies the statute by expressly providing that the submission of claims for physicians' services, or for items or services incident to a physicians' services, which are furnished or supervised by a non-licensed physician are actionable under the statute. In addition, the bill expands the statute's scope to encompass claims for such items or services where the physician's license was obtained through material misrepresentations (such as cheating on a licensure exam), or where the physician falsely represented to the patient that he or she was board-certified in a medical specialty.

The Committee bill makes subject to civil monetary penalties the act of submitting, or causing to be submitted, claims for payment under a program during a period when the person furnishing the

services is excluded from participation in that program. The purpose of this provision is to clarify that civil monetary penalties are applicable in cases where claims are filed by beneficiaries because an excluded individual or entity failed to inform them of the exclusion. In these circumstances, it is the excluded individual or entity, and not the beneficiary, who would be subject to penalties.

Under current law, civil money penalties apply to any individual or entity who causes to be presented to any person a request for payment in violation of an agreement with a State Medicaid agency not to charge a person for an item or service in excess of the amount of allowable payment under the State's Medicaid plan. The Committee bill clarifies that this applies not only to those providers who have a formal agreement with the State Medicaid Agency, but to any providers participating in the State's Medicaid program. All participating providers are subject to the general State plan requirement that they accept Medicaid payment rates as payment in full for services rendered. Providers that bill Medicaid patients for any amounts (other than copayments required under the State Medicaid plan) with respect to covered services are subject to civil money penalties.

The Committee bill authorizes the Secretary to impose civil monetary penalities and exclusion on any individual or entity that gives information to any person concerning Medicare coverage for inpatient hospital services under prospective payment that the individual or entity knows or has reason to know is false or misleading, or that could reasonably be expected to influence the decision as to when to discharge. The amount of the civil monetary penalty is set at $15,000 for each individual with respect to whom false or misleading information was given. The purpose of this provision is to deter hospitals from improperly charging Medicare beneficiaries for inpatient services covered by Medicare and included in the prospective payment rate. The provision is also intended to deter hospitals operating under prospective payment, their employees, or others from providing their Medicare patients with false or misliading information that is intended to encourage premature discharge to the financial advantage of the hospital.

The Committee notes a clarification of intent with respect to the definition of "item of service" in section 1128A(h)(3) of the current statue. Since the enactment of the civil monetary penalty statute, the Congress has enacted the prospective payment system (PPS) for inpatient hopital services furnished under Medicare (section 1886 of the Social Security Act). Consequently, hospitals now bill Medicare for a hospital inpatient stay and receive a payment that encompasses all the hospital inpatient services furnished during that stay. This change in the mechanism and documentation by which hospitals make claims for services under PPS does not affect their status as claims for items or services within the meaning of section 1128A. Other examples of information that hospitals provide under PPS that may constitute a claim include diagnostic and procedural information, cost reports, reports on the numbers and time allocation of interns and residents, and length of stay information.

Under the bill, the Secretary's authority to exclude a person against whom a civil monetary penalty or assessment is imposed would be relocated from section 1128 to section 1128A. The intent

of this change is to make explicit the policy that the Secretary may use a single administrative procedure both for imposition of penalties and assessments and for exclusions.

The Committee bill, in the new section 1128(b)(7), would also authorize the Secretary to exclude an individual or entity who commits an act that would be a basis for a civil money penalty under section 1128A. Thus, the Committee bill would give the Secretary two alternative procedures for exclusion. The Secretary could use section 1128, which does not involve civil money penalties and for which the opportunity for hearing follows the notice of exclusion, or could use section 1128A, which combines actions for exclusion and civil money penalties and which offers an opportunity for hearing prior to the exclusion and penalty. It is the Committee's intent, however, that the Secretary choose one or the other alternative in each instance and that the Secretary not subject an individual or entity to both procedures on the same set of facts.

By consolidating the exclusion and penalty provisions in section 1128A, the bill would also provide a single forum for judicial review of such penalties, assessments and exclusions. Under current law, civil monetary penalties and assessments are subject to review by the Courts of Appeals; whereas, exclusions based on them under section 1128 are subject to review under section 205(g) in the District Courts. This bill would consolidate review in the Courts of Appeals.

Under the bill, the Secretary would not be permitted to initiate an action under the civil monetary penalty provisions later than six years after a claim had been presented. This is the same period provided in the False Claims Act (31 U.S.C. 3731). In addition, the section clarifies that actions may be initiated either by serving notices by any means authorized by Rule 4, Federal Rules of Civil Procedure, including mailing notices by registered or certified mail, or by delivery to the respondent.

The Committee bill would increase a State's share of funds collected under the civil monetary penalty statute in cases involving Medicaid claims. Under current law, the State recovers only its share of the Medicaid funds actually paid as a result of false claims. Under the bill, the State would be paid a portion of the total amount collected under the civil monetary penalty statute, in proportion to its share of the amount it paid for the claims on which the amount collected is based. The intent of this provision is to encourage States to develop and refer civil monetary penalty cases to the Secretary, and to recompose them for their investigative and support services in civil monetary penalty cases.

The bill would authorize the Secretary to issue and enforce subpoenas with respect to civil monetary penalty proceedings to the same extent the Secretary has such authority in other Medicare and Medicaid matters. The Secretary may delegate this authority to the Inspector General for use in an investigation.

If the Secretary has evidence that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty, the Secretary would be permitted to bring an action in District Court to enjoin such activity or to enjoin such persons from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a

civil monetary penalty, or to seek other appropriate relief, including receivership. This provision is modeled on the injunctive authorities of other government agencies with anti-fraud responsibilities, namely, the Securities and Exchange Commission (See 15 U.S.C. 77t) and the Federal Trade Commission (See 15 U.S.C. 53(b)). It is intended that District Courts will grant the Secretary appropriate relief based upon evidentiary showings which are no more burdensome than evidentiary showings required of those agencies.

Criminal Penalties for Acts Involving Medicare and State Health Care Programs (section 4)

The Committee bill would relocate the kickback, bribe and false statements provisions of Medicare (currently Section 1877) and Medicaid (currently Section 1909) into a new section 1128B. The scope of these provisions would be broadened to encompass offenses against the Title V Maternal and Child Health Services Block Grant Program and the Title XX Social Services Block Grant Program. The bill would also extend criminal penalties to persons who present, or cause to be presented, claims for physician's services under Medicare or a State health care program when the person knows that the individual delivering the services was not a licensed physician.

Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners and Providers (section 5)

A State would be required to have in effect a system of reporting information with respect to formal proceedings concluded against an individual or entity by the State licensing authority.

The State would be required to maintain a reporting system on any adverse actions taken by such licensing authority, including any revocation or suspension of a license, reprimand, censure or probation; any dismissal or closure of a proceeding by reason of the practitioner or entity surrendering the license or leaving the State; and any other loss of license whether by operation of law, voluntary surrender, or otherwise. The State would be required to provide the Secretary, or an entity designated by the Secretary, access to such information held by the State's licensing authorities as the Secretary believes to be necessary to carry out his responsibilities under the Social Security Act.

Information regarding licensure actions, surrenders, or losses must be supplied to the Secretary or, under other suitable arrangements made by the Secretary, to another entity in such a form or manner as determined by the Secretary. This information must in turn be disseminated to: Federal agencies administering health care programs, including the Department of Defense, the Veterans' Administration, and the Public Health Service within the Department of Health and Human Services; State licensing authorities; State agencies administering Medicaid, Title V, or Title XX programs; Professional Review Organizations; State Medicaid Fraud Control Units; certain hospitals and other health care entities; the Attorney General and such other law enforcement officials as the Secretary deems appropriate; and, on request, to the Comptroller General. The purpose of this dissemination is to enable these agen-

cies or entities to determine the fitness of individuals to deliver care, to protect the health and safety of program beneficiaries, and to protect the fiscal integrity of the programs.

In the case of hospitals and other health care entities, the Committee bill requires only that licensure information be disseminated to those covered by the Health Care Quality Improvement Act of 1986, P.L. 99-660, and only with respect to physicians or other health care practitioners that have entered into, or may be entering into, an employment or affiliation relationship with the entity, or that have applied for clinical privileges or appointments to the medical staff of the entity. The term "health care entity" is defined for purposes of this bill and section 431 of the Health Care Quality Improvement Act of 1986, 42 U.S.C. section 11151, to include licensed hospitals, health maintenance organizations, group medical practices, and certain professional societies that follow formal peer review processes. The Committee bill provides that any information disseminated under this provision to a hospital or other health care entity is deemed to be disclosed by the Secretary by section 427 of the Health Care Quality Improvement Act of 1986, 42 U.S.C. section 11137, and is subject to the provisions of that Act, 42 U.S.C. sections 11101 et seq.

The Committee recognizes that the requirements regarding licensure information under this bill overlap, to some extent, with certain requirements of the Health Care Quality Improvement Act of 1986, P.L. 99-660. That Act requires each State Medical Board to report to the Secretary of HHS when it revokes or suspends, or otherwise restricts a physician's license, or when it censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct, or when a physician surrenders a license to it. These are the principal licensure actions that States are required to report under the Committee bill. The Health Care Quality Improvement Act also requires the Secretary to provide to hospitals and other health care entities, upon request, information reported to him under that Act regarding a physician or other licensed health care practitioner who has or may have an employment, or affiliation relationship with, or who has applied for clinical privileges or an appointment to the medical staff of, that hospital or entity. The Committee bill requires the Secretary to provide specified licensure information to hospitals and other health care entities, whether requested or not.

To eliminate any unnecessary regulatory burden on State Boards of Medical Examiners, the Committee bill directs the Secretary to provide for the maximum appropriate coordination in the implementation of the reporting requirements under the Committee bill and those under section 422 of the Health Care Quality Improvement Act of 1986, 42 U.S.C. section 11132. The information required to be provided by State Boards of Medical Examiners through the reporting system established by the Secretary under that Act (which may involve the use of a public or private agency for receipt, storage, protection of confidentiality, and dissemination of information) should be structured to meet the requirements imposed under the Committee bill, so as to allow for a single report for both purposes.

To protect both the Secretary and hospitals or other health care entities from duplicate reporting burdens, information disseminated by the Secretary to health care entities under the Committee bill is considered to satisfy the requirements of section 427 of the Health Care Quality Improvement Act of 1986, 42 U.S.C. section 11137.

The Committee bill leaves to the Secretary the discretion to determine whether the Department or some other public or private agency should collect, store, and diseminate the required licensure, information. If the Secretary decides to use an entity other than the Department for this purpose, it is incumbent upon the Secretary to ensure that any organization chosen can provide the information in a timely manner and in such a way as to be useful to the Secretary and other intended recipients.

The Committee believes that it would be excessively burdensome for the Secretary to collect information on all actions commenced or still pending before a State licensure board. The Committee bill therefore provides only for the collection of information respecting concluded actions.

The Secretary would be required to provide suitable safeguards to ensure the confidentiality of the information furnished by State licensing authorities. It is the Committee's expectation that these safeguards will restrict the use of information reported by State licensing authorities for purposes directly related to the performance of legal reponsibilities of the Secretary, State agencies, and other entities receiving information under this section, and will provide appropriate protections for the confidentiality of psychiatric or psychological treatment notes.

Obligations of Health Care Practitioners and Providers (section 6)

The bill would amend section 1156 of the Social Security Act, which currently sets for the obligations of physicians and other practitioners treating Medicare patients to provide quality of care that is medically necessary and appropriately documented, and which provides for the exclusion from Medicare of practitioners who, upon the review and recommendation of a Peer Review Organization, are found to have violated those obligations. The amendment would extend those obligations to encompass all health care services for which payment may be made under the Social Security Act, not just Medicare. Further, the exclusion authority would be extended to encompass violations occurring in, and exclusions from, Medicaid, the Title V Maternal and Child Health Block Grant, and the Title XX Social Services Block Grant.

Exclusion Under the Medicaid Program (section 7)

The Committee bill clarifies current Medicaid law by expressly granting States the authority to exclude individuals or entities from participation in their Medicaid programs for any of the reasons that constitute a basis for an exclusion from Medicare under sections 1128, 1128A, or 1866(b)(2) of the Social Security Act. This provision is not intended to preclude a State from establishing, under State law, and other bases for excluding individuals or entities from its Medicaid program.

The Committee bill also requries States to exclude from their Medicaid programs certan organizations or entities receiving Medicaid funds on a prepayment basis, whether as health maintenance organizations under section 1903(m) or as a case management waiver under section 1915(b)(1). The State would be required to exclude such organizations or entities in either of the following cases.

First, the organization or entity would be required to be excluded whenever a person with an ownership or control interest in the organization or entity, or a person who is an officer, director, agent, or managing employee of the organization or entity, has (1) been convicted of a program-related crime, a crime relating to patient abuse, a crime relating to fraud or financial abuse, obstruction of a criminal investigation, or a crime relating to a controlled substance; (2) been assessed a civil monetary penalty; or (3) been excluded from participation in Medicare or Medicaid or another State health program. Exclusion would be required if the Secretary could exclude such an entity from Medicare under section 1128(b)(8), regardless of whether the exclusion has actually taken place.

Second, mandatory exclusion would apply whenever a organization or entity has, directly or indirectly, a substantial contractual relationship with a person who is convicted, assessed, or excluded as in the first case, above. The purpose of this provision is to exclude from Medicaid organizations or entities from which an unqualified individual benefits financially in a substantial way, for example through a consulting arrangement, even though the individual does not meet the statutory definition of a person with an ownership or control interest or an officer, director, agent, or managing employee. The provision is not intended to reach normal, arms-length commercial transactions in which a supplier or other contractor happens to have an employee who has been convicted of a crime but who has no relationship with the organization or entity.

Failure on the part of the State to exclude organizations or entities as required by this provision would result in the loss of Federal Medicaid matching payments for any payments the State makes to any health maintenance organizations or case management waivers. Matching payments would be disallowed from the date the organization or entity first begins receiving Medicaid funds on a prepayment basis, or on the date the individual is convicted, assessed, or excluded as specified, whichever occurs last.

In the view of the Committee, the incentives for underserving in order to maximize financial gain are extremely strong in a Medicaid prepayment context, particularly where the proportion of Medicaid patients enrolled in a particular plan is large. Experience in California in the early 1970's, and in other States in more recent times, demonstrates that Medicaid patients, who are by definition poor, are far more vulnerable than affluent consumers to the denial of medically necessary care in a prepayment setting, and that Medicaid taxpayer dollars are at risk of being diverted to uses other than the delivery of medical services. In a March, 1987, report, the General Accounting Office cited the need for careful attention to ownership and control arrangements and financial performance in Medicaid prepaid plans in order to prevent the diver-

sion of program funds. Medicaid: Lessons Learned From Arizona's Prepaid Program (HRD–87–14).

As explained in the discussion of proposed section 1128(b)(6)(C), above, the Committee bill establishes, as one of the grounds on which the Secretary may exclude an entity from the Medicare, Medicaid, and other State health care programs, the substantial failure of a health maintenance organization or a case manager to provide medically necessary items and services to Medicaid beneficiaries. To further assure that Medicaid patients enrolled under prepayment arrangements will receive medical care that meets acceptable standards, and also to protect the Medicaid program from financial abuse, this section of the Committee bill would require the exclusion of organizations or entities which have associated with them individuals against whom criminal or civil sanctions have been imposed. The purpose of this provision is to induce these organizations or entities to sever all relationships with such individuals, and more broadly to maximize the likelihood that only reputable, legitimate providers are allowed to deliver services to Medicaid patients on a prepayment basis. The Secretary is without authority to waive this provision.

In order to assure that it will receive Federal Medicaid matching funds in connection with its prepayment arrangements, a State will have to assure that the organizations or entities with which it has contracted are not subject to exclusion under this provision. The Committee expects that the Secretary, in implementing this section, will direct the States to screen all prepayment contractors for compliance with these requirements prior to initial participation and no less frequently than each contract renewal thereafter.

Miscellaneous and Conforming Amendments (section 8)

The Committee bill would amend Titles V (Maternal and Child Health Services Block Grant Program), XVIII (Medicare), XIX (Medicaid) and XX (Social Services Block Grant Program) of the Social Security Act to clarify that no payment could be made for any item or service, other than an emergency item or service, furnished by an individual or entity excluded from participation in those programs. With respect to Titles V and XX, the Committee bill also prohibits payments for items or services provided at the medical direction of a physician who is excluded from participation. With respect to Titles XVIII and XIX, the Committee bill also prohibits payments for items and services made at the medical direction or on the prescription of a physician who is excluded from the program, but only when the person delivering the item or service knew or had reason to know that the physician was excluded.

The bill would amend Title XVIII (Medicare) to provide that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both section 1128 and section 1866(b)(2) (termination of provider agreements) with respect to a determination or determinations based on the same underlying facts and issues.

The bill would amend the Controlled Substances Act to add exclusion from Medicare or a State health care program as a basis for the denial, revocation, or suspension of registration to manufacture, distribute or dispense a controlled substance.

Clarification of Medicaid Moratorium Provisions of Deficit Reduction Act of 1984 (Section 9)

Section 9 of the bill would clarify the Medicaid moratorium provision in section 2373(c) of the Deficit Reduction Act of 1984 (P.L. 98–369).

The history of the Medicaid moratorium begins in 1981. Under section 2171 of the Omnibus Budget Reconciliation Act (OBRA) of 1981, P.L. 97–35, States were given certain flexibility in structuring their Medicaid "medically needy" programs. They were allowed to limit coverage to certain categories of persons and to vary the scope and services offered. However, regulations implementing the OBRA 1981 provisions also permitted States to change financial eligibility rules by allowing them to impose a narrower—i.e., "more restrictive"—standards and methodologies to evaluate income and resources for Medicaid eligibility. The OBRA 1981 changes had not given the Secretary the authority to allow the States such flexibility with regard to financial eligibility standards and methodologies.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, P.L. 97–248, amended the Medicaid statute to clarify that Congress did not intend to change the policies governing income and resource standards and methodologies for determining eligibility of the medically needy from those in effect prior to OBRA 1981. Section 137(a)(8) of TEFRA specified that the methodology to be used in determining income and resource eligibility for the medically needy must be the same methodology used under the relevant cash assistance program. However, because of an overly literal interpretation of the requirement that non-cash financial eligibility rules strictly follow those of the relevant cash assistance program, the regulations implementing this provision led to unintended, and in some cases, undesirable results. States with financial eligibility rules for their non-cash assistance beneficiaries that were less restrictive than the corresponding cash assistance rules were improperly subjected to financial sanctions by the Secretary.

The Deficit Reduction Act (DEFRA) of 1984, P.L. 98–369, did not directly amend the Medicaid statute to allow the States to use financial eligibility standards and methodologies for their medically needy programs that in every case were less restrictive than those of the corresponding cash assistance programs. Instead, section 2373(c) of DEFRA establishes a moratorium period during which the Secretary is prohibited from taking any compliance, disallowance, penalty, or other regulatory action against a State because a State, in determining eligibility for non-cash Medicaid beneficiaries, uses an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology. The Secretary was directed to report to Congress within 12 months of enactment of DEFRA (July 18, 1984) on the impact on States and beneficiaries of applying income and resources standards and methodologies under the cash assistance programs to non-cash eligibles. The moratorium on Secretarial actions against States expires 18 months after the submission of this report. The purpose of the DEFRA moratorium is to give the Congress, the Secretary, and the States the time and information necessary to resolve the eligibility policies at issue through a statutory

change. The Committee notes that the Secretary has not yet submitted the required report, and that the moratorium remains in effect at this time.

In January, 1985, the Health Care Financing Administration (HCFA) issued a Medicaid Action Transmittal (85–1) to all State Medicaid agencies setting forth HCFA's interpretation of the DEFRA moratorium provision. The Transmittal states that the moratorium applies only where the "existing approved State plan" is, or would be, in violation of the requirement, as interpreted by HCFA, that States apply the same methodology or standards to their non-cash assistance Medicaid beneficiaries. The Transmittal concludes, "Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods."

This interpretation is erroneous and inconsistent with the intent of Congress in enacting the DEFRA moratorium. As is evident from the Joint Statement of Managers of the Committee of Conference on DEFRA, H. Rep. 98–861, 98th Cong., 2nd Sess. (1984) at pp. 1366–1368, the intent of the moratorium was to protect States whose non-cash income and resources policies were less restrictive than the corresponding cash assistance rules from adverse Federal actions. HCFA's refusal to approve State plan amendments to permit medically needy and other non-cash eligibility policies that are less restrictive than corresponding cash assistance methodologies or standards is directly contrary to the intent of the DEFRA moratorium.

A related problem has also come to the Committee's attention. When a Medicaid applicant or beneficiary who owns his own home is admitted to a hospital or nursing home, the value of the residence continues to be disregarded in determing whether he is eligible for Medicaid, providing that he intends to return home. However, if the individual no longer intends to return home, and if his spouse or dependent becomes a countable resource that can increase his resources beyond the allowable level. In the past, under Federal Medicaid policy, such an individual would not lose Medicaid eligibility if he was making a bona fide effort to dispose of the property. Proceeds from the eventual sale of the house could then be used to repay the Medicaid benefits paid during this period of eligibility and to finance the costs of the patient's continuing nursing home care until he had again reduced his countable resources to the allowable level and reestablished eligiblity for Medicaid coverage. This "bona fide effort to sell" policy promoted continuity of care for the nursing home resident in these circumstances and increased the financial benefit for the State and the Federal government by giving the resident enough time to sell his residence at its reasonable market value rather than being forced to dispose of it quickly at a price that might be well below market.

Recent administrative interpretations by the Department could change this policy, forcing premature sale of the homes of institutionalized Medicaid applicants and beneficiaries. For example, one interpretation would require the value of an unsold house to be

counted as an available resource even though the applicant or beneficiary is making a bona fide effort to dispose of it. Another interpretation would force premature sale of homes by some nursing home residents who still have reasonable expectations of returning home, thereby undermining the policy objective of encouraging frail elderly or disabled people to avoid institutionalization whenever possible.

The Committee bill clarifies that the moratorium on the Secretary's compliance, disallowance, penalty, or other regulatory actions against a State applies. The moratorium applies to State Medicaid plans, as well as to the operation or administration of a Medicaid program by a State pursuant to that State plan. The moratorium applies to State policies and procedures reflected in the State plans; to amendments or other changes in State plans submitted to the Secretary at any time before or after enactment; and to State operation or program manuals that are submitted to the Secretary at any time before or after enactment. The moratorium applies regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the State plan, the amendment or other change, or the operation or program manual. The moratorium applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Security income). The moratorium applies both to the "medically needy," as defined in section 1902(a)(10)(C) of the act, and to the "optional categorically needy," as defined in section 1902(a)(10)(A)(ii).

The moratorium applies to MECQ reviews and error rates and other adverse regulatory actions on the Secretary's part from October 1, 1981, until 18 months after the secretary submits the report, as originally required by DEFRA, on the appropriateness of, and the impact on States and beneficiaries of applying cash assistance standards and methodologies to the medically needy and optional categorically needy groups.

Under the Committee bill, the DEFRA moratorium allows States to maintain eligibility rules for non-cash beneficiaries that are less restrictive than the cash assistance rules. For example, State Medicaid plans or operating manuals could provide that medically needy or optional categorically needy aged, blind or disabled applicants in nursing homes, who have marginally excess resources on the first day of the month, can still attain Medicaid eligibility during that month if they deplete their excess resources during the month, SSI rules notwithstanding. Similarly, SSI does not count resources worth up to $6,000 if they produce income; under its Medicaid program, however, a State could permit residents in nursing homes or other institutions to keep income-producing property worth more than $6,000, especially real estate (including contracts for deed), and use the income produced to offset the monthly cost of their care. State plans could also permit non-cash beneficiaries to exclude from countable resources one car, regardless of its value or whether the car is necessary for employment or regular medical care. Similarly, burial plots could be excluded as a resource even though the plots are not intended solely for the use by non-cash beneficiaries or their immediate family members. Household goods

and personal effects also could be excluded even if their equity value exceeds $2,000. A State plan or policy could establish less restrictive medically needy income levels for an SSI-related elderly couple than is allowed a two-person AFDC-related household. Also, a State plan could treat income used to pay family support payments (pursuant to court order or agreement with a District Attorney) as unavailable to the payor for purposes of determining medically needy eligibility. A State plan could permit exclusion of the equity in non-homestead property. A State plan could permit use of community property laws or other divisions of income and property specified under the State Medicaid plan or operating manuals in determinations of eligibility for medically needy aged, blind and disabled, as long as such laws did not make ineligible for Medicaid (whether as individuals or couples) married individuals living together who otherwise would be eligible.

Finally, the Committee bill would also restore, for the duration of the moratorium, the previous Medicaid policy in effect on October 1, 1981, governing the period when homeownership by an institutionalized individual is permitted and the period of time allowed for the sale of the individual's home. The home-ownership moratorium would apply for purposes of determining the eligibility of beneficiaries and applicants who seek to qualify for Medicaid as medically needy individuals, as optional categorically needy individuals under the special income standard (up to 300 percent of the SSI payment standard) for those in medical institutions, or as other optional categorically needy institutionalized persons.

Limitation of Liability of Medicare Beneficiaries with respect to Services Furnished by Excluded Individuals and Entities (Section 10)

Under current law, the Secretary may assess a civil monetary penalty against an individual or entity that has been excluded from Medicare and submits claims for medical items or services if the Secretary has initiated a termination proceeding. In addition, payment may not be made where the individual or entity knowingly and willfully made any false statement or misrepresentation in requesting payment. The Secretary may, after appropriate notice, also terminate a provider agreement if the Secretary determines that the provider has misrepresented a material fact in requesting payment.

The Committee bill would require that Medicare payment be made for claims submitted by a beneficiary for services rendered by an individual or entity that has been excluded from Medicare participation if the beneficiary has no knowledge of, or has no reason to know of, the exclusion. The Secretary would be required to notify the beneficiary of the exclusion of the individual or entity, and to specify in regulations a reasonable period of time that the Medicare payments would continue.

The purpose of this provision is to protect Medicare beneficiaries from financial harm when the excluded provider fails to inform them of the exclusion. The Committee wishes to stress that individuals and entities excluded from Medicare, as well as the Secretary, have an affirmative obligation to notify all patients eligible for Medicare or State health care programs of the exclusion and the

fact that the programs will not make payment for their services during the period of exclusion.

Definition of Person With Ownership or Control Interest (Section 11)

Under current law, providers participating in Medicare, Medicaid, and the Title V Materal and Child Health Services Block Grant must disclose to the Secretary and the appropriate State agencies the identities of all persons with "ownership or control interests." A person with an "ownership or control interest" in an entity includes a person who is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any property or assets of the entity. The person's interest must equal or exceed $25,000 or 5 percent of the total property and assets of the entity. The Committee bill would eliminate the $25,000 threshold, leaving 5 percent of the entity's total property and assets as the test for this category of persons with "ownership or control interests."

Conditional Approval of Renal Dialysis Facilities (Section 12)

Under current law, the Secretary is authorized to terminate Medicare certification for a facility furnishing end-stage renal disease maintenance dialysis services, if the facility is determined not to be in compliance with the conditions for Medicare coverage for such facilities. Such an acton terminates all Medicare payments for current and future patients, until the facility is recertified. Termination of payments for current patients may pose a serious risk to these vulnerable patients or a substantial barrier to their access to this life-saving procedure. The Secretary may therefore be reluctant to exercise this termination authority, even in cases of serious failures to comply with applicable conditions for coverage. However, the alternative of seeking to bring the facility into compliance through persuasion and technical assistance, while continuing Medicare payments, may not be effective.

The Committee bill would give the Secretary an alternative, intermediate sanction of denying Medicare payments for new patients, but continuing payments for existing patients. If the facility's failure to comply with the conditions for coverage poses a serious problem, and needs to be corrected for the proper implementation of the program, but does not present an immediate risk to the health or safety of the patients, the Secretary would effectively use such a sanction to bring the facility into compliance without disrupting the services for current patients.

The facility would have to be given a reasonable opportunity, prior to the imposition of this sanction, to correct its deficiencies. If a sanction were imposed under this authority, the facility would then have the right to an administrative hearing and to judicial review, in accord with existing statutory authorities.

Fraud Involving Medicare Supplemental Insurance (Section 13)

Current law provides criminal penalties for individuals who "knowingly or willfully" make, cause to make, or induce the making of, a false statement or representation of a material fact with respect to the compliance of a Medicare supplemental health insurance policy with Federal standards. The Committee bill pro-

vides that, in order to be subject to criminal penalties, an individual in these circumstances must act "knowingly and willfully."

Standards for Anti-Kickback Provisions (Section 14)

Current law provides criminal penalties for individuals or entities participating in Meicare or Medicaid that knowingly and willfully offer, pay, solicit, or receive bribes, kickbacks, or rebates under certain circumstances. These actions are defined as felonies and are subject, upon conviction, to fines of up to $25,000 and imprisonment for up to 5 years. Sections 4 (c), (d), and (e) of the Committee bill recodify these authorities, now found at sections 1877(d) and 1909 of the Social Security Act, in a new section 1128B(b).

It is the understanding of the Committee that the breadth of this statutory language has created uncertainty among health care providers as to which commercial arrangements are legitimate, and which are prescribed. Neither the Attorney General nor the Inspector General of the Department of Health and Human Services has issued any regulations which would offer guidance to health care providers in this regard. The Committee bill therefore directs the Secretary, in consultation with the Attorney General, to promulgate regulations specifying payment practices that will not be subject to criminal prosecution under the new section 1128B(b) and that will not provide a basis for exclusion from participation in Medicare or the State health care programs under the new section 1128(b)(7). These regulations must be published in final form within two years after enactment of this Act. In order to assure adequate time for public comment and agency consideration of those comments, the Committee bill requires the Secretary to publish a proposed rule within one year after enactment.

The Committee expects that the Secretary will consult with affected provider, practitioner, supplier, and beneficiary representatives before publishing proposed rules, and that the rules will, to the extent practical, contain criteria relative to prevalent controversies or ambiguities under the law in addition to any generic criteria that might apply to business arrangements generally.

The Committee also believes that a mechanism for periodic public input is necessary to ensure that the regulations remain relevant in light of changes in health care delivery and payment and to ensure that published interpretations of the law are not impeding legitimate and beneficial activities. Accordingly, the Committee expects that the Secretary will formally re-evaluate the anti-kickback regulations on a periodic basis and, in so doing, will solicit public comment at the outset of the review process.

Effective dates (Section 15)

In general, the amendments made by this bill would become effective 15 days after enactment. They would not apply to exclusion or civil monetary penalty proceedings that are commenced before this effective date. The provisions establishing mandatory five-year minimum exclusion periods for conviction of certain crimes would be convictions occurring on or after the date of enactment.

The provisions of the bill requiring States to report information on licensure actions to the Secretary would be effective with respect to Medicaid payments for calendar quarters beginning more

than 30 days after enactment, whether or not final regulations have been issued, unless the Secretary determines that State legislation (other than appropriations legislation) is required. In such a case, the State would not be considered to have failed to meet the requirements before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

The authorization for the Secretary, in connection with civil monetary penalty remedies, to seek injunctive relief against the disposal of assets would take effect on enactment.

The bar on certain physician misrepresentations for purposes of civil monetary penalties applies to claims for services performed on or after the general effective date of the bill, regardless of when the misrepresentation was made. The Committee notes that some physician misrepresentations are already subject to sanctions under current law and these would not be affected by the bill with regard to claims filed prior to enactment. The filing of claims for physician services (or services incident to physician services), where the individual furnishing or supervising that service is not licensed in the State where the service is rendered, is already a violation of the criminal provisions of the Social Security Act, if it is done knowingly and willfully. This is also a violation of current section 1128A, if done knowingly or with reason to know. The amendments in this bill should not be construed to mean that such conduct occurring prior to the enactment of this legislation is not actionable under these current provisions.

III. Budget Effects of the Bill

1. COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made; the Committee agrees with the cost estimate prepared by the Congressional Budget Office which is included below.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

With respect to clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee advices that the Congressional Budget Office costs estimate included below indicates the change in budget authority and no or new increase tax expenditures as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 11, 1987.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 1444, the Medicare and Medicaid Patient and Program Protection Act of 1987, as ordered reported by the Ways and Means Committee on May 5, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1444.

2. Bill title: Medicare and Medicaid Patient and Program Protection Act of 1987.

3. Bill status: As ordered reported by the Committee on Ways and Means on May 5, 1987.

4. Bill purpose: To amend titles XI, XVIII, and XIX of the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions relating to those programs.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Budget authority	3	2	2	2	2
Outlays	6	4	3	3	3

The costs of this bill fall within functions 550 and 570.

Basis of Estimate

The bill requires medical providers, states and federal agencies to exchange information on the medical, legal and financial conduct of medical providers. The purpose of this information exchange is to protect beneficiaries from providers with criminal, patient abuse, fraud and other convictions. In addition, the bill requires that physicians who have defaulted on health education loan or scholarship obligations be excluded from federal reimbursement under Medicare and Medicaid. The bill contains extensive fines and penalties to see that the provisions are enforced. Finally, the bill contains four minor provisions which clarify other areas of Medicare and Medicaid law but have no federal costs. The bill necessitates exchange of data and merging of information from a number of sources. Based on estimates of the volume of data that will be

necessary for (1) hospitals to exchange with state governments, (2) states to exchange with the federal government and (3) executive branch departments to exchange with each other, CBO estimates that it will be necessary to establish a computerized data systems. This system, similar to that established for exchange of other types of medical information, will require federal and state developmental and operating costs. The estimate assumes that these administrative costs will be greatest in the first two years when computer development and implementation costs will be borne. After the first two years, the cost of the system will be approximately $50,000 per state per year in addition to $500,000 per year in executive branch costs.

The budget authority estimates reflect the distribution of costs between the Medicare and Medicaid programs. Medicaid budget authority would increase by the increase in Medicaid costs. Medicare budget authority would not change significantly as a result of the additional Medicare costs.

6. Estimated cost to state and local government: State and local medicaid administrative costs will increase by approximately $1.5 million in 1988 and $1 million in subsequent years.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Donald Muse.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

IV. Other Matters Required To Be Discussed Under the Rules of the House

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made, the bill, H.R. 1444, was ordered favorably reported to the House of Representatives by voice vote.

2. OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the committee reports that the need for this legislation has been confirmed by the oversight findings of the Subcommittee on Health. As noted in the above Section on "Background and Need for Legislation," the General Accounting Office presented to the Subcommittee its findings based on its report of May 1, 1984, entitled, "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses" (GAO/HRD-84-53). In preparing the report, the GAO reviewed license revocations and suspensions in three States and followed up on the practitioners to determine whether they were still receiving Medicare and Medicaid reimbursement. Many of the provisions included in this legislation resulted from the recommendations made by the GAO as a result of their investigation.

In addition, the Subcommittee took testimony from the Inspector General of the Department of Health and Human Services who has

responsibility for enforcing the fraud and abuse laws designed to protect Medicare and Medicaid patients. The I.G. made recommendations to the Subcommittee to expand current authority to fill many of the gaps in current law. Many of these recommendations were included in H.R. 1444.

The Subcommittee on Health and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce held a joint hearing on March 19, 1985, on the Medicare and Medicaid Program and Patient Protection Act of 1985, H.R. 1370 and the related bills, H.R. 1369 and H.R. 1091 (Report 99-80, Part 1). The Medicare and Medicaid Program and Patient Protection Act of 1985, H.R. 1868, was the successor bill to H.R. 1370 and H.R. 1369 in the 99th Congress. The Committee bill, H.R. 1444, is in turn the successor legislation to H.R. 1868. The House suspended the rules and passed the bill, H.R. 1868, on June 4, 1985.

On April 1, 1987, the Subcommittee on Health of the Committee on Ways and Means met and reported H.R. 1444, without amendment, by voice vote, a quorum being present. On May 8, 1987, the Committee on Ways and Means met and reported H.R. 1444, without amendment, by voice vote, a quorum being present.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

4. INFLATION IMPACT

Pursuant to clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, the Committee states that the reported bill will have no inflationary impact on prices or costs in the operation of the national economy.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE V—MATERIAL AND CHILD HEALTH SERVICES BLOCK GRANT [1]

* * * * * * *

USE OF ALLOTMENT FUNDS

Sec. 504. (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its de-

scription of intended expenditures and statement of assurances transmitted under section 505.

(b) Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; [or]

(5) providing funds for research or training to any entity other than a public or nonprofit private entity[.]*; or*

(6) payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A, or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded pursuant to section 1128 or section 1128A from participation in the program under this title.

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

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PART A—GENERAL PROVISIONS

* * * * * * *

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) * * *

* * * * * * *

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) * * *

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds [$25,000 or] 5 per centum of the total property and assets of the entity; or

* * * * * * *

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, and XIX, any hospital, nursing facility, [or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

[(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

[(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.] *or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8).*

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any [institution, organization, or agency] *entity* of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an [institution, organization, or agency,] *entity,* an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the [institution, organization, or agency,] *entity,* or who directly or indirectly conducts the day-to-day operations of the [institution, organization, or agency.] *entity.*

* * * * * * *

[EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

[SEC. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

[(1) shall bar from participation in the program under title XVIII each such individual otherwise eligible to participate in such program;

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of

such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such plan for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

[(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(b) Whenever the Secretary determines, with respect an entity, that a person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such entity, is a person described in section 1126(a), the Secretary—

[(1) may bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such entity otherwise eligible to participate in such program;

[(2) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of the determination, and may require each such agency to bar the entity from participation under the State plan for such period as he specifies, which may not exceed the period established pursuant to paragraph (1); and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such entity of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(c) Whenever the Secretary makes a final determination to impose a civil money penalty or assessment against a person (including an organization, agency, or entity) under section 1128A relating to a claim under title XVIII or XIX, the Secretary—

[(1) may bar the person from participation in the program under title XVIII, and

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State

plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) may require each such agency to bar the person from participation in the program established by such plan for such period as he shall specify, which in the case of an individual shall be the period established pursuant to paragraph (1), and

[(B) may waive the requirement of subparagraph (A) to bar a person from participation in such program where he receives and approves a request for such waiver with respect to that person from the State agency referred to in that subparagraph.

[(d) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(e) Any person or entity who is the subject of an adverse determination made by the Secretary under subsection (a), (b), or (c) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(f) For purposes of subsection (a), a physician or other individual is considered to have been "convicted" of a criminal offense—

[(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

[(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

[(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; or

[(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.]

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h)):

(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program.

(2) CONVICTION RELATING TO PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

(3) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) EXCLUSION OR SUSPENSION UNDER FEDERAL OR STATE HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or ecxcluded from participation, or otherwise sanctioned, under—

(A) Any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health cafe, or

(B) a State health care program,

for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—An individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines had committed an act which is described in section 1128A or section 1128B.

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required by section 1124 or section 1126.

(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be neccessary to verify such information.

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the perfornamce of the statutory functions of the Inspector Gereral.

(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

(14) DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS.—Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exlude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requestrs that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under title XVIII or XIX.

(c) NOTICE EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion.

until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(2), the period) of the exclusion.

(B) In the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) Subject to paragraph (3), the Secretary shall exercise the authority under subsection (b) in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under a program under title XVIII.

(B) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Service fully and currently informed with respect to any actions taken in response to the response.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) The provisions of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participa-

tion under this section or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion affected under this section or section 1128A.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title, or

(3) any program receiving funds under title XX or from an allotment to a State under such title.

(i) CONVICTED DEFINED.—For purposes of subsections (a) and (b), a physician or other individual is considered to have been "convicted" of a criminal offense—

(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; or

(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)),

a claim (as defined in subsection (i) [75](2)) that the Secretary determines [is for a medical or other item or service]—

[(A) that the person knows or has reason to know was not provided as claimed, or

[(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or]

(A) is for a medical or other item or service that the person knows or has reason to know was not provided as claimed,

(B) is for a medical or other item or service and the person knows or has reason to know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or has reason to know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

(D) is for a medical or other item or service furnished during a period in which the person was excluded under the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b); or

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service *(or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given).* In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. *In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.*

* * * * * * *

(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a

State agency *(or other requirement of a State plan under title XIX)* not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), *or (D) an agreement pursuant to section 1866(a)(1)(G), or*

(3) gives to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or has reason to know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(c)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money [penalty or assessment] *penalty, assessment, or exclusion* under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. *The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by rule 4 of the Federal Rules of Civil Procedure.*

* * * * * * *

(d) In determining the amount or scope of any [penalty or assessment] *penalty, assessment, or exclusion* imposed pursuant to subsection (a) or (b), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

* * * * * * *

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount [equal to the State's share of the amount paid by the State agency] *bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid* for such claim.

* * * * * * *

(g) A determination by the Secretary to impose a [penalty or assessment] *penalty, assessment, or exclusion* under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) may not be raised as a defense to a civil

action by the United States to collect a [penalty or assessment] *penalty, assessment, or exclusion* assessed under this section.

(h) Whenever the Secretary's determination to impose a [penalty or assessment] *penalty, assessment, or exclusion* under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, *the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),* and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a [penalty or assessment] *penalty, assessment, or exclusion* has become final and the reasons therefor.

* * * * * * *

(j) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(k) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

[PENALTIES] *CRIMINAL PENALITES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS*

SEC. [1909] *1128B.* (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under [a State plan approved under this title] *a program under title XVIII or a State health care program (as defined in section 1128(h)),*

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, [or]

(4) having made application to receive any such benefit or payment for the use and benefit or payment for the use and

benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, *or*

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under title XVIII or a State health care program and knows that the individual who furnished the service was not licensed as a physician,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under [this title] *the program,* be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than fives years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under [this title] *title XIX* is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of [this] *that* title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [this title] *title XVIII or a State health care program,* or

(B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [this title] *title XVIII or a State health care program,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing or any item or service for which payment may be made in whole or in part under [this title] *title XVIII or a State health care program,* or

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which

payment may be made in whole or in part under [this title] *title XVII or a State health care program,* or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under [this title] *title XVIII or a State health care program,* shall be guilty of a felony and upon conviction thereof, shall be find not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under [this title] *title XVIII or a State health care program,* if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; [and]

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services[.]*;*

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under title XVIII or a State health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1861(u)), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, the the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity; and

(D) any payment practice specified by the Secretary in regulations promulgated pursuant to section 15(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, [or home health agency (as those terms are employed in this title)] *home health agency, or other entity for which certification is required under title XVIII or a State health care program* shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfuly—

(1) charges, for any service provided to a patient under a State plan approved under [this title] *title XIV,* money or

other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under [this title,] *title XIX,* any gift, money donation, or other consideration (other than a charitable religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

* * * * * * *

Part B—Peer Review of the Utilization and Quality of Health Care Services

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Sec. 1156. (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under [title XVIII], *this Act* to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under [such title]—

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under [title XVIII] *this Act,* has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations,

the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide such services on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded form eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective at such time and upon such reasonable notice to the public and to the practitioner or person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in [title XVIII] *this Act* with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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USE OF CARRIERS FOR ADMINSTRATION OF BENEFITS

SEC. 1842. (a) * * *

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(j)(1) * * *

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(2) Subject to paragraph (3) the sanctions which the Secretary may apply under this paragraph are—

[(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or]

(A) excluding a physician from participation in the programs under this title for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is [barred from participation in the program] *excluded from participation in the programs* under this title pursuant to this subsection.

(3)(A) The Secretary may not [ban] *exclude* a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

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Part C—Miscellaneous Provisions

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EXCLUSIONS FROM COVERAGE

Sec. 1862. (a) * * *

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[(d)(1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

[(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

[(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

[(C) has furnished services or supplies which are determined by the Secretry on the basis of information acquired by the Secretary in the administration of this title to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.

[(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home health services such determination shall be effective in the manner health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public

that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(4) The Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of any determination made under the provisions of this subsection.

[(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.]

(e) No payment may be made under this title with respect to any item or service (other than an emergency item or service) furnished—

(1) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1128 or section 1128A from participation in the program under this title; or

(2) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1128 or section 1128A from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

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(h)(1) * * *

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(4) The Secretary may deny payment under this title, in whole or in part and for such period of time as the Secretary determines to be appropriate, with respect to the implantation or replacement of a pacemaker device or lead of a manufacturer performed by a physician and provider of services after the Secretary determines (in accordance with the procedures established under [paragraphs (2) and (3) of subsection (d)] *subsections (c), (f), and (g) of section 1128* that—

(A) the physician or provider of services has failed to submit information to the registry as required under paragraph (1)(C),

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

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[(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person

who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).]

* * * * * * *

[(b) An agreement with the Secretary under this section may be terminated—

[(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

[(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a).

Any termination shall be applicable—

[(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or post-hospital extended

care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

[(4)(A) with respect to home health services or hospice care furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual more than 30 days after such effective date, and

[(5) with respect to any other items and services furnished on or after the effective date of such termination.]

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(c)(1) Where [an agreement filed under this title by a provider of services has been terminated by the Secretary] *the Secretary has terminated or has refused to renew an agreement under this title with a provider of services;* such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination *or nonrenewal* has been removed and that there is reasonable assurance that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910(a), and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.

(3) Where [an agreement filed under this title by a provider of services has been terminated by the Secretary] *the Secretary has terminated or has refused to renew an agreement under this title with a provider of services;* the Secretary shall promptly notify each State agency which administers or supervises the administra-

tion of a State plan approved under title XIX of such termination *or nonrenewal.*

* * * * * * *

(h)(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

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DETERMINATIONS; APPEALS

SEC. 1869. (a) * * *

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[(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).]

* * * * * * *

[PENALTIES

[SEC. 1877. (a) Whoever—

[(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any applicatioin for an benefit or payment under this title,

[(2) at any time knowingly and willingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

[(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

[(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty or a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

[(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

[(A) in return for referring an individual to a person for the furnishing or arranging for furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(2)Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bride, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

[(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title.

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(3) Paragraphs (1) and (2) shall not apply to—

[(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; [358]

[(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services; and [359]

[(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under this title if—

[(i) the person has a written contract, with each such individual or entity which specifies the amount to be paid

the person, which amount may be a fixed amount or a fixed percentage of the value of the purchasers made by each such individual or entity under this contract, and

[(ii) in the case of an entity that is a provider of services, the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity.[360]

[(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.]

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

* * * * * * *

(h)(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A),

(B) finds that the facility's deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this title shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary's decision to restrict payments under this subsection shall be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A), or (B), the Secretary terminates the agreement under this title with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * * * *

(d)(1) Whoever knowingly [or] *and* willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

* * * * * * *

SEC. 1886. (a) * * *

* * * * * * *

(f)(1) * * *

* * * * * * *

[(3) The provisions of paragraphs (2), (3), and (4) of section 1862(d) shall apply to determinations under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1862(d)(1).]

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

* * * * * * *

LIMITATION OF LIABILITY OF BENEFICIARIES WITH RESPECT TO SERVICES FURNISHED BY EXCLUDED INDIVIDUALS AND ENTITIES

SEC. 1890. Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an exluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(23) except as provided in *subsection (g) and in* section 1915 and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.

* * * * * * *

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, [respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor;] *the information described in section 1128(b)(9);*

(39) provide that the State agency shall [bar] *exclude* any specified [person] *individual or entity* from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 *or section 1128A,* and provide that no payment may be made under the plan with respect to any item or service furnished by such [person] *individual or entity* during such period;

* * * * * * *

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act; [and]

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920[.]*;*

[(47)] *(48)* provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing addres[.]*; and*

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921.

* * * * * * *

[(l)] *(o)* Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of section 1611(e)(1)(E) to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a health maintenance organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions), or

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B).

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

[(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such

provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or]

(2) with respect to any amount expended for an item or service (other than an emergency item or service) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A, or

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded pursuant to section 1128 or section 1128A from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

* * * * * * *

[(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.]

* * * * * * *

PENALTIES

SEC. 1909. (a) * * *

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[(d)] *(e)* Whoever accepts assignments described in section 1842(b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) * * *

[(2) restricts—

[(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or

[(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care,

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.]

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

* * * * * * *

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 1921. (a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 1902(a)(49) is that the State must provide for the following:

(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to agencies administering Federal health care programs,

(2) to licensing authorities described in subsection (a)(1),

(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

(4) to utilization and quality control peer review organizations described in part B of title XI,

(5) to State medicaid fraud control units (as defined in section 1903(q)),

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such

hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act), and

(7) to the Attorney General and such other law enforcement officials as the Secretary deems approrpriate, and

(8) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentaility of such of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) APPROPRIATE COORDINATION.—The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1921.] *1922.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

* * * * * * *

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

* * * * * * *

LIMITATIONS ON USE OF GRANTS

SEC. 2005. (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

(1) * * *

* * * * * * *

(7) for any child day care services unless such services meet applicable standards of State and local law; [or]

(8) for the provision of cash payments as a service (except as otherwise provided in this section)[.]*; or*

(9) for payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A, or

(B) at the direction or on the prescription of a physician during the period when the physician is excluded pursuant

to section 1128 or section 1128A from participation in the program under this title.

* * * * * * *

SECTION 304 OF THE CONTROLLED SUBSTANCES ACT

DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION

SEC. 304. (a) A registration pursuant to section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Attorney General upon a finding that the registrant—

(1) * * *

* * * * * * *

(3) has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances or has had the suspension, revocation, or denial of his registration recommended by competent State authority; [or]

(4) has committed such acts as would render his registration under section 303 inconsistent with the public interest as determined under such section[.]*; or*

(5) has been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act.

* * * * * * *

SECTION 2373 OF THE DEFICIT REDUCTION ACT OF 1984

MISCELLANEOUS TECHNICAL AMENDMENTS

SEC. 2373. (a) * * *

* * * * * * *

[(c)(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined to be in violation of section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

[(2) The moratorium period is the period beginning on the date of the enactment of this Act and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

[(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

[(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.]

(c)(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to the moratorium period described in paragraph (2) by reason of such State's plan described in paragraph (5) under title XIX of the Social Security Act (including any part of the plan operating pursuant to section 1902(f) of such Act), or the operation thereunder, being determined to be in violation of clause (IV), (V), or (VI) of section 1902(a)(10)(A)(ii) or section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's (or its operation) having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section, provided that such plan (or its operation) does not make ineligible any individual who would be eligible but for the provisions of this subsection.

(2) The moratorium period is the period beginning on October 1, 1981, and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

(5) In this subsection, a State plan is considered to include—

(A) any amendment or other change in the plan which is submitted by a State, or

(B) any policy or guidance delineated in the Medicaid operation or program manuals of the State which are submitted by the State to the Secretary,

whether before or after the date of enactment of this Act and whether or not the amendment or change, or the operating or program manual was approved, disapproved, acted upon, or not acted upon by the Secretary.

(6) During the moratorium period, the Secretary shall implement (and shall not change by any administrative action) the policy in effect at the beginning of such moratorium period with respect to—

(A) the point in time at which an institutionalized individual must sell his home (in order that it not be counted as a resource); and

(B) the time period allowed for sale of a home of any such individual,

who is an applicant for or recipient of medical assistance under the State plan as a medically needy individual (described in section 1902(a)(10)(C) of the Social Security Act) or as an optional categorically needy individual (described in section 1902(a)(10)(A)(ii) of such Act).

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